U.S. Department of Health and Human Services
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Health Resources and Services Administration

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Opening Doors

Information from HRSA's Health Care for the Homeless Program

www.hchirc.com

Putting Prevention Into Practice: Tuberculosis

While the resurgence of tuberculosis (TB) in the late 1980's and early 1990's has abated in recent years, TB remains a serious public health problem among homeless persons.

TB is spread when someone with the disease coughs or sneezes, thereby placing bacteria into the air where others may breathe them in and become infected. Most people who are exposed to TB bacteria and become infected never develop the disease. These people have latent TB infection (LTBI). The bacteria remain alive and may become active at some point in the future. Individuals with weakened immune systems who have LTBI, or who become newly exposed to TB bacteria, are more likely to develop active TB than individuals with healthy immune systems. HIV infection, AIDS, substance abuse, diabetes, kidney disease and low body weight, all conditions that are common among people who are homeless, weaken the immune system and increase risk for developing TB upon exposure to the bacteria.

Homeless shelters and other settings where individuals are in close proximity create conditions that contribute to the spread of the infection among populations that are at risk. Health care providers who serve people who are homeless are well aware of the association between homelessness and tuberculosis and are continually looking for ways to prevent the spread of TB among their clients.

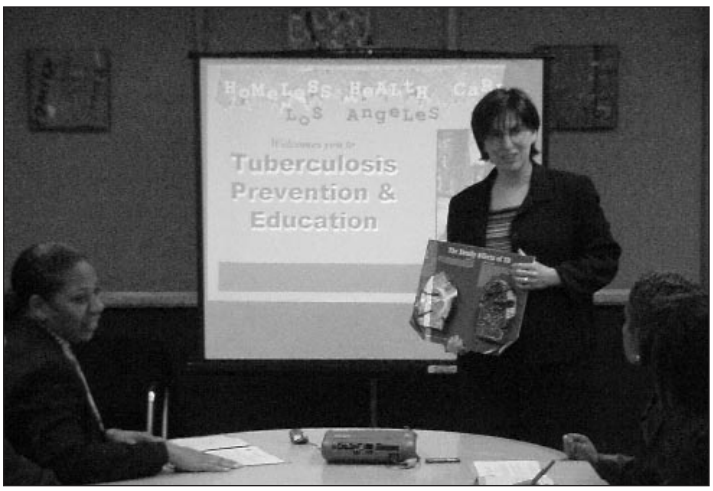
In This Issue

Disease prevention and health promotion are an important part of comprehensive health care services. This issue presents information on models of tuberculosis prevention, ways to improve nutrition among homeless adults and children and the benefits of an innovative training program in a homeless shelter.

We'd like to know about HCH programs that have developed disease prevention, health promotion and wellness programs for their clients. Contact the HCH Information Resource Center at (888) 439-3300, ext 247.

TB Prevention Training

The Training and Education Department of Homeless Health Care Los Angeles (HHCLA) has developed a TB prevention program for staff of homeless service agencies. These workers can play an important role in both the identification of individuals with TB infection and disease and in TB prevention.



TB prevention training at Homeless Health Care Los Angeles.

Homeless shelters are advised to conduct a TB assessment of all clients upon intake and refer all persons with TB symptoms or history of TB disease for medical evaluation as quickly as possible. Individuals who are suspected of having TB disease should be housed away from others until they are determined not to be contagious. Homeless health care providers should refer all individuals with TB disease to the local county or city tuberculosis control program for treatment. There are a number of ways that agencies, especially shelters and drop-in centers, can take steps to prevent the transmission of TB infection. HHCLA recommends:

- Conduct TB assessments of all clients.
- Develop written TB policies and procedures.
- Conduct environmental assessments at regular intervals.
- Provide adequate ventilation with the use of

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INSIDE

Preventing Physical and Emotional Stress

People have to "own" change to make it last, and health professionals who partner with clients by building on strengths and addressing needs are more likely to help create changes that last. That is the conviction of Georgiana Herzberg, PhD, Department of Occupational Therapy, Nova Southeastern University, in Ft. Lauderdale, Florida. Dr. Herzberg incorporated this philosophy into the design of a pilot project, Interdisciplinary Training in a Homeless Shelter (ITHS), at the Salvation Army Emergency Shelter in Ft. Lauderdale. The project is funded by the Health Resources and Services Administration's Bureau of Health Professions.

The ITHS approach recognizes that the employment opportunities available to homeless people frequently involve work that is stressful, both physically and emotionally. Day labor and jobs that require heavy lifting, prolonged periods of standing and repetitive motion all carry increased risks for injury. These work environments often offer few opportunities for personal control and choice, situations that can increase emotional stress. It is important, therefore, to find ways to help individuals cope with these demands so they can compete more successfully in the workforce. Dr. Herzberg notes, "Most people are motivated for a better life and there are concrete ways we can help."

Using a multi-disciplinary approach, the program offers on-site training for students and needed services to shelter residents. For example, optometry students conduct eye examinations and refer individuals with vision or eye problems for further evaluation and treatment. Audiology and speech pathology students conduct assessments to identify individuals with hearing or communications disorders. Students of occupational therapy and students of conflict analysis and resolution work with people, both individually and in groups, to increase communications skills, boost self- esteem, develop constructive ways of dealing with emotions and learn practical ways to maintain health and wellness.

Opening Doors is published quarterly by the Health Resources and Services Administration's Bureau of Primary Health Care.

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Bureau of Primary Health Care
Jean Hochron, MPH, Chief
Health Care for the Homeless Branch
Susan Whitney, Project Officer

Weekly groups at the shelter focus on health promotion, prevention and personal development. Topics include:

- Body mechanics, including techniques for proper posture, standing, lifting, walking and sitting.
- Energy conservation. How to "work smarter."
- Task prioritization. Teaching systems and techniques for organizing and sequencing tasks.
- Recognizing physical stresses. Using injury prevention techniques and devices, such as earplugs, stretching, body positions and shoes that fit properly.
- Memory improvement techniques and exercises.
- Conflict management strategies. Appropriate responses to stressful interpersonal dynamics. For example, aggressive behaviors that are protective on the "street" are not advantageous in the workplace.
- Stress management and relaxation techniques.
- Taking charge and finding meaning and purpose in life. Setting job goals and life goals. Self-reflection and ongoing re-assessment of goals.
- Money management. Planning and budgeting.
- Communications skills.

The goal of the project is to give people tools and skills to be productive in work and life roles, to maintain physical and emotional health and to develop positive interpersonal relationships. Dr. Herzberg believes this is best accomplished through the efforts of allied health professionals working in concert with people who are homeless and those who serve them. The ITHS is a model for training students to take more active roles in health care services for people who are homeless. But just as importantly, it is a model for client empowerment.

For more information, contact Dr. Herzberg at (954) 262-1216, glh@nova.edu or visit the website at www.nova.edu/~scottg/ITHS. ▲

Put Prevention Into Practice

Preventive services should be a routine part of patient care. To accomplish this, you can find help in *A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach,* Agency for Health Care Research and Quality, (AHRQ), October 2001. This guide presents a formal system for delivering clinical preventive services. Topics include assessing readiness for change, prevention practices, developing preventive care protocols and delivering services. Worksheets, health risk profiles and clinical tools are included. Available from the AHRQ website at *www.ahcpr.gov/ppip/manual/manual.htm.*

fans, open doors and windows.
- Use pleated air filters and replace them at regular intervals.
- Provide TB skin testing for staff every 6-12 months.
- Provide TB education for staff and clients.
- Train staff to be alert to TB signs and symptoms.
- Provide easy access to tissues and instructions for how and when to use them.
- In shelters, place beds head to foot with three-foot wide aisles between beds.
- Develop systems to help clients adhere to TB medication regimens.
- Designate a staff person as a resource for TB related issues.

HHCLA has produced a companion resource, *Tuberculosis Prevention Guide For Homeless Service Providers,* which provides detailed information on these recommendations, fact sheets on TB and other resources for TB prevention and control.

For more information, contact Eve Rubell, MPH, at (213) 744-0724 or erubell@hhcla.org

TB Net

TB Net is a bi-national (United States and Mexico) tuberculosis patient tracking and referral system operated by the Migrant Clinicians Network (MCN) to facilitate continuity of care and TB treatment adherence for migrant workers, immigrants and other mobile populations. TB Net is supported by the Texas Department of Health with funds from the Centers for Disease Control and Prevention. Any health care provider serving patients who move from one part of the country to another may become a TB Net member clinic, free of charge, and offer this service to patients.

Completion of TB treatment is critical to recovery from the disease and key to the control of multi-drug resistant TB. TB Net helps patients in three ways:
- Receives a copy of the patient's medical record (with patient consent) from the treating clinic and maintains a central medical record that can be accessed by all subsequent treating clinics.
- Supplies member health clinics with wallet-sized treatment records that are used to summarize a patient's TB treatment history. This portable record, which also displays the TB Net toll-free number, can be presented to the next health care provider so the full medical record can be sent to the new treatment team.
- Maintains a resource directory of health facilities throughout the country and publicizes a toll-free number for patients who need help in finding treatment services.

Given the demographics of the patients served, the TB Net staff are bi-lingual, in English and Spanish, and offer low literacy materials and information in both languages.

Since it was established in 1996, TB Net has facilitated the tracking and transfer of medical records for more than 1,200 patients. MCN has found that there is a high treatment completion rate for patients enrolled in the program. Some patients have moved as many as four or five times during the course of treatment. Although TB Net was initially developed for migrant workers and immigrants, the system is equally appropriate for health care providers who serve people who are homeless, many of whom are also mobile and at high risk for TB infection and disease. Jeanne Laswell, RN, BSN, TB Net project manager, would like to publicize TB Net among HCH providers so that "homeless persons who move around can also take advantage of the service. This is a program for anyone who is mobile and in treatment for TB."

For more information, contact Jean Laswell, RN, BSN, at (800) 825-8205 or jlaswell@migrantclinician.org

A Model for TB Control and Prevention

The Wasatch Homeless Health Care (WHHC) Program in Salt Lake City, Utah, in collaboration with the county health department, operates a comprehensive TB prevention program. The program includes: TB testing upon entry in a homeless shelter; further medical evaluation for individuals with positive skin tests; treatment for those with active disease; and housing for people who are receiving Directly Observed Therapy (DOT) and are no longer contagious.

Housing, co-managed by the WHHC and the Housing Authority of the County of Salt Lake, is provided for up to eight people in four apartments. DOT patients have regular medical follow-up and chest x-rays. They are visited weekly by the WHHC case manager to ensure treatment adherence and address other needs. Monte Hanks, WHHC client services manager, finds that the model has prevented TB re-infection and controlled the spread of disease by enabling WHHC and the county to monitor patients throughout treatment. Homeless TB patients benefit from a safe and stable environment in which to recover from the disease.

WHHC has produced a manual for care coordinators, including TB protocols and program procedures, that is available to other HCH programs with an interest in developing tuberculosis prevention and supervised housing for individuals with tuberculosis.

For more information, contact Monte Hanks at (801) 364-5572 or monte@fourthstreetclinic.org.

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Tuberculosis Prevention (Continued from page 3)

Tuberculosis Ultraviolet Shelter Study (TUSS)

The Tuberculosis Ultraviolet Shelter Study (TUSS) is assessing the effect of short wavelength upper room ultraviolet germicidal irradiation (UVGI) and ventilation in preventing the spread of TB bacteria in homeless shelters in five cities. This six-year study is being conducted by researchers at Saint Vincent's Manhattan Hospital and the Harvard School of Public Health. Philip W. Brickner, MD, TUSS principal investigator at Saint Vincent's, states that preliminary data suggest that staff and clients in homeless shelters are "at substantial risk for exposure to TB infection."

Richard Vincent, project manager and lighting specialist, reports that the study is also yielding information related to the engineering aspects of UVGI. He notes that it is important to determine what is required in terms of ventilation, placement of UV fixtures, amount of energy and airflow to maximize the effect of UVGI on TB bacteria. Project guidelines on these and other engineering questions have been accepted by the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) and published in peer review articles.

Dr. Brickner believes that the TUSS research design could be applied, with modification, to other areas of public health interest such as the potential of upper air ultraviolet air disinfection in combating illnesses such as influenza, measles or adenoviruses.

Given the ravages of tuberculosis and other infectious illnesses on individuals at high risk for disease, the hope of finding effective and efficient ways to prevent TB by killing the pathogen is extremely appealing. Dr. Brickner and his colleagues expect that findings from the TUSS data will be available in about three years.

For more information contact Philip Brickner, MD, at drpwb@aol.com or Richard Vincent at vincentral@msn.com. Both Dr. Brickner and Mr.Vincent can be reached at (212) 604-8025. ▲

TB Resources

- The HHCLA *Tuberculosis Prevention Guide for Homeless Service Providers* is available for $10.00. Contact: Eve Rubell, MPH, Director of training and education, HHCLA, 2330 Beverly Blvd., Los Angeles, CA 90057 or (213) 744-0724 or *erubell@hhcla.org*
- HCH providers are invited to join TB Net, free of charge. Contact: Jeanne Laswell, RN, BSN, TB Net project manager, Migrant Clinicians Network, P.O. Box 164285, Austin, TX 78716 or (800) 825-8205 or *jlaswell@migrantclinician.org*

Nutrition Plays Critical Role in Prevention

Poor nutrition is linked with increased risk for obesity, diabetes, cardiovascular disease and a host of other physical, developmental and psychological disorders. While the importance of good nutrition is clear, maintaining a healthy diet is a particular challenge for people who are homeless. For adults and children alike, hunger is a daily reality. They rely on shelters, soup kitchens and other food distribution programs for most or all of their daily food intake. With few options and choices of what to eat, many people who are homeless are poorly nourished.

Health Care for the Homeless (HCH) providers understand the critical role that nutrition plays in primary and secondary prevention. They have developed programs and assembled resources to improve the nutritional status of people who are homeless.

In NYC, the Children's Hospital at Montefiore's Division of Community Pediatrics and the Children's Health Fund (CHF) have developed several nutrition resources for homeless service providers. Prepared with support from the Health Resources and Services Administration's Bureau of Primary Health Care, these resources are available at the CHF website, *www.childrenshealthfund.org.*

- *Homeless Family Facility Nutrition Guidelines* provides model nutrition policies and procedures to assist family homeless shelters.
- *Improving the Nutrition Status of Homeless Children: Guidelines for Homeless Family Shelters* is a detailed report which summarizes relevant literature and presents an overview of family shelter nutrition practices, guidelines and recommendations.
- An appendix to the report provides nutrition and Internet resources, screening tools and examples of "best practices" that have been shown to optimize the nutrition status of children.

Josefine Wendel, MS, RD, nutrition consultant, CHF, reports that the materials were developed in collaboration with homeless shelters to ensure they are realistic and consistent with food resources typically available.

For more information on the Children's Health Fund, contact Michael Lambert at (212) 535-0779 or mlambert@montefiore.org. ▲

Meeting the Challenges of Rural Homelessness

by Pat Post, HCH Clinicians' Network

Homelessness is a serious and growing problem in rural America. Nationwide, nine percent of surveyed homeless people live in nonmetropolitan areas. In some rural counties, the reported incidence of homelessness is significantly higher than in major metropolitan areas. Because supportive services are scarce in rural areas, the burden of homelessness is disproportionately heavy.

Structural Causes. Modern rural homelessness is primarily a function of structural change in the economy resulting in unemployment, falling incomes and the lack of affordable housing. Economic hardship is exacerbated by geographic and transportation barriers, lack of health insurance, and unavailable or inaccessible health and social services, particularly specialty care, substance abuse treatment, and mental health services.

"Most single homeless adults aged 30-55 aren't eligible for Medicaid, and general medical assistance in the counties where it exists isn't enough to help," says Mary Clay Santineau, PA, of Starting Point in Chippewa Falls, Wisconsin. "The only clinic in Chippewa County that sees clients on a sliding scale is so full that it turns away one-third of the people seeking services. Many families need $70-$80 medications to treat ADHD, diabetes or mental illness, but can't afford them; so they get off their medications and can't maintain regular housing."

Clinical Changes. Health problems tend to be more complicated in rural patients who are homeless, according to Health Care for the Homeless (HCH) clinicians. "Our homeless clients from rural areas have had little to no health care in the past," says Jan Wilson, FNP, homeless health care coordinator at Valley Health Systems in Huntington, West Virginia. "High blood pressure, diabetes, substance abuse, coronary artery disease, and obesity are all common in West Virginia, but they are more advanced in our rural homeless clients because they have remained untreated longer."

The mobile outreach team from the Clinica Sierra Vista Homeless Program in Bakersfield, California, found a 47-year-old farm worker with diabetes living in the desert with gangrene up to his knee. "We transported him to the emergency room where his leg had to be amputated," reports homeless coordinator Marie Aylward-Wall, MSN, PHN. HCH clinicians also found a 33-year-old pregnant woman living in her car with two children. She was pre-eclamptic with extremely high blood pressure, a medical emergency. They were unable to save the baby, but without their help, the whole family would have been lost.

Rural Service Models. Homeless assistance models in rural communities vary according to size and distance from urban areas. In those large enough to support health and social services, strategies include community partnerships linking formal and informal support systems, multi-service centers, and a hub-and-spoke outreach and referral model between rural and urban communities. In remote rural communities with minimal capacity to provide services, two strategies are frequently used: mobile outreach, and referrals to urbanized areas with established homeless services.

The Yellowstone City-County Health Department's Health Care for the Homeless project in Billings, Montana uses a hub-and-spoke model. Besides serving homeless people who migrate to cities from outlying areas, a mobile van reaches unsheltered persons in remote areas without HCH services, says HCH project manager Lori Hartford, RN.

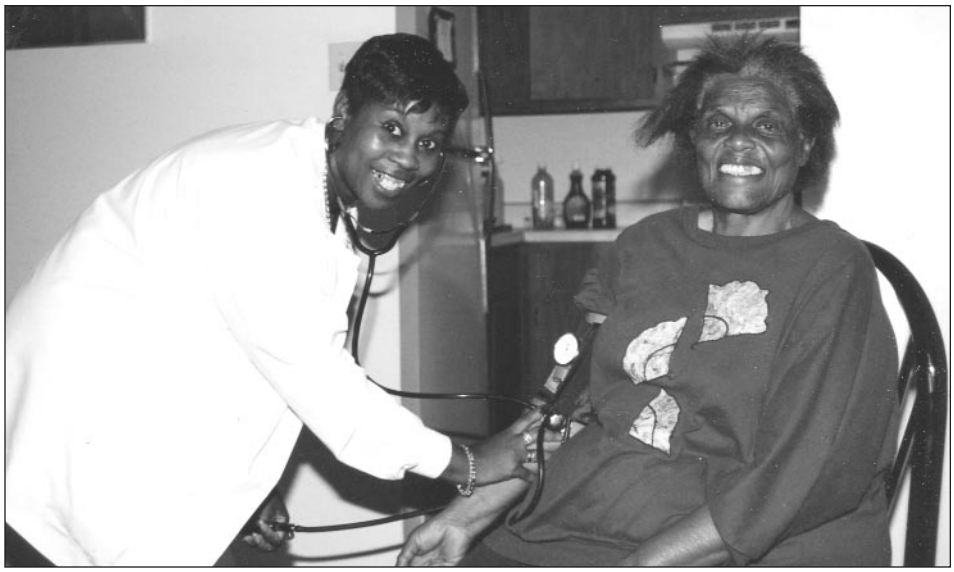
Recommendations. Service providers recommend ways to end, ameliorate or prevent rural homelessness

- Provide transportation assistance
- Expand health coverage and facilitate access to health and social services
- Develop comprehensive services in rural communities responsive to needs of homeless people
- Coordinate rural service delivery systems;
- Increase outreach to "hidden" homeless people
- Promote cultural competence
- Help families and individuals cope with hardship before they become homeless.

Information presented is excerpted from *Hard to Reach: Rural Homelessness & Health Care,* published in January 2002 by the National Health Care for the Homeless Council with support from the Bureau of Primary Health Care. To order a hard copy, visit the NHCHC website *www.nhchc.org.* A pdf version of the document can be downloaded from *www.nhchc.org/publist.html.*

The Collaborative Approach to Diabetes Prevention and Control

The HRSA-funded Health Disparity Collaborative is being used by HCH providers to improve nutrition for individuals with diabetes as part of the chronic care model that incorporates self-management to prevent complications of disease. Through participation in the Midwest Diabetes 1 Collaborative, Veronica Richardson, RN, BSN, director of chronic disease care management at Grace Hill Neighborhood Health Centers in St. Louis, Missouri, implemented a diabetes chronic care model. The model placed heavy emphasis on nutrition, screening and community support for diabetes self-management.



Grace Hill Health Care coach and patient.

Grace Hill operates six community-based health centers, including one that is dedicated exclusively to serving people who are homeless. In partnership with seven homeless shelters throughout the city, Grace Hill employs several interventions to improve the health status of persons with diabetes and prevent the onset of diabetes among individuals at risk.

- A dietitian helps shelter staff plan and offer healthier meals, using donated foods and including more fresh produce and protein to balance carbohydrate-rich diets. Artificial sweeteners for use in place of sugar are made available.
- Diabetic patients who are homeless are referred to shelters with facilities for storing insulin, medications and glucose testing supplies.
- Incentives, such as shower shoes, socks and toiletries, are distributed to encourage patients to enroll in the diabetes registry and to come in for regular glucose monitoring and case management.
- Diabetic patients are taught the principles and tools of self-management. A picture book of "good" and "bad" foods is used for individuals with low literacy.
- Patients are given pocket-sized cards that contain their medical record number, signs and symptoms of hypoglycemia and information on where to go for a snack in the event of a hypoglycemic episode.
- A special clinic for homeless diabetic patients addresses comprehensive medical and social service needs. Nutrition, exercise, adherence to medication regimens and other self-management activities are specifically geared to the circumstances of being homeless.

Nutrition Resource for Homeless Shelters

Homeless shelters that meet criteria are eligible for reimbursement for meals for children and adults in day care through the Child and Adult Care Food Program (CACFP). For more information visit *www.fns.usda.gov/cnd/care/cacfp/cacfphome.htm.*

Ms. Richardson states, "Participation in the collaborative has given us the opportunity to apply the chronic care model to a population with very special needs. We're continuing to work with our community partners to improve care for our diabetic patients."

Christine Reller, RN, MSN, HCH project manager at the Hennepin County Community Health Department, is equally enthusiastic about her participation in the Midwest Cluster Collaborative. She finds that diabetes is prevalent among their patients. Health behaviors, such as poor diet and skipping medications, contribute to disease severity and are common. By implementing the chronic care disease model and by providing access to the resources, tools and expertise of the collaborative, Hennepin County has been able to make small, but important, changes in service delivery that have grown as the program has matured.

Nutrition education among clients in shelters was an important first step. Ms. Reller states, "It was very basic...information about portion size, what is a healthy meal and how to

(continued on next page)

HCH INFORMATION RESOURCE CENTER Connections

Call for Posters, Tools, Art Work (and More!) for the 2002 HCH Conference

Share your innovative ideas, creative talents, and program materials with your peers at the 2002 National HCH Conference on June 27-29 at the Drake Hotel, Chicago, IL. Consider any or all of the following opportunities.

- **Submit abstracts for poster presentation** at the conference. The conference theme is *Immediate Needs...Lasting Solutions,* and the poster session will showcase clinical and programmatic research and innovative work being done by HCH grantees and related organizations from around the country.
- **Share clinical and programmatic tools** with your peers at the Resource and Tools Exchange. Items for display or distribution may include:
  – program brochures
  – intake/encounter forms
  – client satisfaction survey tools
  – research/education tools/reports
  – manuals/training materials/fact sheets
  – bylaws/policies & procedures
  – clinical protocols
  – quality assurance guidelines
  – publications/newsletters
  – videos

Please note: If materials are available in electronic form, email them to *hch@prainc.com* for inclusion in the tools collection on our website.

- **Showcase artwork** by clients or staff of HCH programs. A wide range of media will be accepted, including quilts, writing, photography, sculpture and drawing.
- **Display and sell merchandise** produced by HCH clients and staff. Items such as T-shirts, artwork, greeting cards and jewelry can be sold in our Resource Room.

For more information about any of these HCH conference opportunities, contact Art Dicker at Policy Research Associates, (888) 439-3300 or *adicker@prainc.com.* Or click on the "Conference" button online at *www.hchirc.com.*

The Health Care for the Homeless Information Resource Center is operated by Policy Research Associates, Inc., (PRA) for the Health Resources and Services Administration's Bureau of Primary Health Care. Contact Nan McBride, project director, PRA, 345 Delaware Ave., Delmar, NY 12054.

How Can We Help You?

Contact our information specialist at (888) 439-3300 ext. 247 or *hch@prainc.com* or visit our website at *www.hchirc.com.*

Diabetes Collaborative (Continued)

choose foods wisely, when offered alternatives." In keeping with the model, the program enrolls patients in the diabetes registry, provides case management, offers treatment of acute illness and chronic disease management and conducts patient education in self-management, a key component of secondary prevention.

For more information on Grace Hill Neighborhood Health Centers, contact Veronica Richardson at ((314) 539-9638 or veronicar@gracehill.org.

For more information on the Hennepin County Community Health Department, contact Christine Reller at (612) 348-8824 or christine.reller@co.hennepin.mn.us. ▲

Pediatrician and health assistant with patients at the Grace Hill-Hadley Health Clinic.

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Program Update

Six New HCH Access Points Funded By HRSA

HRSA recently funded six New Access Points to provide health care services to homeless people. Two of the sites are expansions of existing HCH projects, the other four are new starts, bringing the total number of federally-funded HCH projects to 143.

Coastal Family Health Center, Inc., of Biloxi, Mississippi, is the primary source of health care services for the indigent and uninsured people in a three-county area. Coastal will establish a mobile van to deliver multi-disciplinary services to 3,700 homeless clients.

Family Health Center of Southwest Florida in Ft. Myers is a community health center with over 35 years of experience with underserved populations. They will open two new sites to serve an additional 2,000 homeless people in the Ft. Myers area.

Health Care for the Homeless, Inc., in Orlando, provides primary medical services to homeless people in the Central Florida area. Federal funding will allow them to expand their services to include 4,000 new homeless clients.

Ventura County Public Health Department, in Ventura, California, will open their doors to 5,000 homeless clients, many of whom are undocumented, indigent, and suffer from mental illness. The new project encompasses six counties in Southern California.

Alameda County Health Care Services Agency, in Oakland, California, an existing HRSA-funded HCH project, will establish "VanCamp," a mobile van that will cover 14 new sites, making health care services available to an additional 1,900 homeless people.

San Francisco Community Clinic Consortium (SFCCC), also an existing HRSA-funded HCH project, is a partnership of nine non-profit community health centers in Northern California. SFCCC will target 1,500 homeless adults living on the streets or in shelters in the Mission District of San Francisco.

Thinking of applying for funding under the New Access Point initiative? For information about eligibility and guidance in preparing your application, visit:
www.bphc.hrsa.gov/dpspnewcenters/

The HCH Clinicians' Network announces a free electronic newsletter for those working with homeless children and adolescents. Each issue will feature resources, news and events. Readers are invited to share opinions and resources, and most importantly, to use the newsletter as a vehicle for asking questions of colleagues. To become a member of this online community, email your request to *network@nhchc.org* and put Subscribe Pediatric Interest Group in the subject line of your message.

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